

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8957

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118949

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Edwin Last Collins		4. DATE OF DEATH Month August Day 20 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1883
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Collins		14. MOTHER'S MAIDEN NAME Hester Ann Story	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 34 9135	
17. INFORMANT Mrs. Ruth Collins, Denton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6100 Cardio-Vascular Disease-Renal DUE TO Hypertrophied Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 19 1960 to Aug. 19 1961 , that (I) (we) last saw the deceased alive on Aug 19 1961 , and that death occurred at 8:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Dawson O. George M.D.		22b. DATE SIGNED 8-21-61	
22c. PHYSICIAN'S NAME (Type) Dawson O. George		22d. ADDRESS Denton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/61	
23c. NAME OF CEMETERY OR CREMATORY Grove Cemetery		23d. LOCATION (City, town, or county) (State) Caroline County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.H. Hollis & Son.		25a. REC'D BY REGISTRAR DATE AUG 23 '61	
ADDRESS Preston, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

W.H. Hollis & Son.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8958

CERTIFICATE OF DEATH

10046

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. LENGTH OF STAY IN 1b <u>30y R.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hillsboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CYRENE LEE Hammond</u>				4. DATE OF DEATH Month Day Year <u>8 31 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.H. Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Polly Bellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>131-12-2797</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 420.1 DUE TO <u>Arterio Sclerosis</u> Probably <u>6 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Aug 30 1961</u> <u>Aug 31 1961</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 30 1961</u> , that (I) (we) last saw the deceased alive on <u>12:30 A 1961</u> , and that death occurred on <u>12:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Paul Knotts</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>				22d. ADDRESS <u>Denton, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandtown Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Hillsboro Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doherty</u>				ADDRESS <u>Eaton Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 11 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

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STATE OF NEW YORK

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IN SENATE
JANUARY 10, 1900

REPORT OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8959

CERTIFICATE OF DEATH

08950

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 8 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro	
4. NAME OF DECEASED (Type or print) Mamie L. Jenkins		d. STREET ADDRESS None	
5. SEX Female 6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH 8 9 19 61		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gunnings		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rev. Amous Jenkins		Address Greensboro, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Cardiovascular Disease (c) Spastic Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 10 19 61 to Aug. 9 19 61 , that (I) (we) last saw the deceased alive on Aug. 9 19 61 , and that death occurred at 11:45 A from the causes and on the date stated above.		22a. SIGNATURE Charles H. Stonesifer M.D.	
22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	
22d. ADDRESS Greensboro, Maryland		22e. REC'D BY REGISTRAR Aug 14 '61	
22f. REGISTRAR'S SIGNATURE Arthur S. Kenna		22g. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22h. DATE THEREOF 8-12-61		22i. NAME OF CEMETERY OR CREMATORY Cokers	
22j. LOCATION (City, town or county) Greensboro, Maryland		22k. (State)	
22l. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulaie		22m. ADDRESS Greensboro, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08951

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First <u>LANE</u> Middle		4. DATE OF DEATH <u>AUG</u> Month <u>15</u> Day <u>1961</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 2, 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM SLOAN</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE GRIFFITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS Mary Swift, Denton, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>60</u> , to <u>Aug 15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 15</u> , 19 <u>61</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dawson D. George</u> M.D.		ADDRESS (Street, city or town, state) <u>Denton, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DAWSON D. GEORGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 18, 1961</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. George</u> ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of crematorium		18. Signature of cremation		19. Signature of cremation		20. Signature of cremation	
21. Signature of cremation		22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation		28. Signature of cremation	
29. Signature of cremation		30. Signature of cremation		31. Signature of cremation		32. Signature of cremation	
33. Signature of cremation		34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation		40. Signature of cremation	
41. Signature of cremation		42. Signature of cremation		43. Signature of cremation		44. Signature of cremation	
45. Signature of cremation		46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation		52. Signature of cremation	
53. Signature of cremation		54. Signature of cremation		55. Signature of cremation		56. Signature of cremation	
57. Signature of cremation		58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation		64. Signature of cremation	
65. Signature of cremation		66. Signature of cremation		67. Signature of cremation		68. Signature of cremation	
69. Signature of cremation		70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation		76. Signature of cremation	
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81. Signature of cremation		82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation		88. Signature of cremation	
89. Signature of cremation		90. Signature of cremation		91. Signature of cremation		92. Signature of cremation	
93. Signature of cremation		94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation		100. Signature of cremation	

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VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08952

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walkertown		d. STREET ADDRESS Walkertown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Cook Last Liden		4. DATE OF DEATH Month August Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 10 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Cook		14. MOTHER'S MAIDEN NAME Jane Armstrong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT W. Elbert Liden, Jr., Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO 199X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 199X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-27 1961 to 8-24 1961 , that (I) (we) last saw the deceased alive on 8-24 1961 , and that death occurred on 12-20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Trever		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT W. TREVER, M.D.		22d. ADDRESS 202 Dover Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29, 1961	
23c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		23d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DATE AUG 31 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, with word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8962

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08953

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 12 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Jerome Last Mack				4. DATE OF DEATH Month 8 Day 11 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1872		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Field Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 153-03-3855		17. INFORMANT Charles Shoemaker Address 329 Jackson Street Manville, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound to RT Temple DUE TO Shock, Visceral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Self Inflicted DUE TO (c) Self Inflicted INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 3 a.m. 8-11-1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His Home		20f. (City or town) (County) (State) Rural Marydel Caroline Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dawson O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-61		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulain				ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR 15 '61	
				24b. REGISTRAR'S SIGNATURE Charles L. Thomas			

DATE SIGNED
8-12-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8963

CERTIFICATE OF DEATH

Reg. Dist. No. 08954

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLIE</u> First <u>McNATT</u> Middle <u>McNATT</u> Last		4. DATE OF DEATH <u>AUG</u> Month <u>20</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 7, 1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN McNATT</u>		14. MOTHER'S MAIDEN NAME <u>GEORGEA CLIMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS ELLIS MURPHY GREENSBORO</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left-sided heart failure</u> (c) <u>Hypertensive Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>11 or more</u> <u>several</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24-Feb-1961</u> to <u>Present</u> , that I last saw the deceased alive on <u>8-August-1961</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>16 N 2nd St., Denton, Md 22440</u> DATE SIGNED <u>Aug 22, 1961</u>			
ACTUAL SIGNATURE <u>Dale R. Kollman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u> <u>16 N. Second St., Denton, Maryland</u> <u>August 22, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 23, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENSBORO</u>		22d. LOCATION (City, town, or county) (State) <u>GREENSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virgo Woodson</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u> DATE <u>AUG 24 '61</u>	
24b. REGISTRAR'S SIGNATURE			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON

1
8964
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08955

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN TB 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Friendship		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hilda Middle Meeds Last Williamson		4. DATE OF DEATH Month August Day 25 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1897
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cyrus Meeds		14. MOTHER'S MAIDEN NAME Ida Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Melvin W. Williamson, Preston, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral (Chronic) DUE TO Pulmonary Cysts DUE TO Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 25-30 yrs 25-30 "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 2, 1961 to Aug 25, 1961 that (I) (we) last saw the deceased alive on Aug 25, 1961 and that death occurred at 1:48 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. H. B. Plummer		22b. DATE SIGNED 8/28/61	
22c. PHYSICIAN'S NAME (Type) DR. H. B. PLUMMER		22d. ADDRESS Preston Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 27, 1961	
23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		23d. LOCATION (City, town, or county) (State) Near Preston, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR AUG 31 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Frame			

BP

10/1/57

UNITED STATES GOVERNMENT

10/1/57

(1)

(1)

TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM THE SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing an investigation or administrative action.]

